EXHIBIT B

PART 3 OF 5

IBM Low, Medium and High Deductible PPO Options:

- Out-of-network providers/facilities (inpatient and outpatient): 60% of the usual and prevailing rate, or 60% of the billed fee, whichever is less, after the annual medical deductible is met. You will also be responsible for a $150 penalty for inpatient care when you fail to precertify.
- In-network providers: 60% of the negotiated fee after the annual medical deductible is met.
- In-network facilities: You will receive no benefits.
- Network providers may not bill you or the Plan for care that has not been precertified. If this occurs, you are still responsible for paying your deductible, coinsurance, copayment, whichever is applicable.

IBM High Deductible PPO w/HSA Option:

- Out-of-network providers/facilities (inpatient and outpatient): 55% of the usual and prevailing rate, or 55% of the billed fee, whichever is less, after the annual medical deductible is met. You will also be responsible for a $150 penalty for inpatient care when you fail to precertify.
- In-network providers: 55% of the negotiated fee after the annual medical deductible is met.
- In-network facilities: You will receive no benefits.
- Network providers may not bill you or the Plan for care that has not been precertified. If this occurs, you are still responsible for paying your deductible, coinsurance, copayment, whichever is applicable.

Only care that is medically necessary will be covered. You or your facility is responsible for sending medical records for review by the mental health Plan Administrator to determine medical necessity. If the care is determined not to be medically necessary, you will not receive benefits under the Plan. Care that is not precertified is subject to medical necessity review by the mental health plan upon claims submission. (See "MMHC Alternate Levels of Care" for more information.)

IBM EPO Option

Under the IBM EPO, you must call the Clinical Referral Line to precertify all inpatient and outpatient mental health and substance abuse services. If you do not precertify the care, benefits will not be covered under the Plan.

Medical Necessity

The administrator certifies treatment for benefit coverage only if it's considered to be medically necessary. To be medically necessary treatment must:

- Be medically required.
- Have a strong likelihood of improving your diagnosed psychiatric or substance abuse condition.
- Be the least intensive level of appropriate care for your diagnosed condition in accordance with:
  - Generally-accepted psychiatric and mental health practices.
  - The professional and technical standards adopted by the mental health plan.
- Not be rendered mainly for the convenience of the member, the member's family or the provider.
- Not be custodial care. (See "What the IBM Medical Plan Does Not Cover" for a definition of custodial care.)

Note: Determination of medical necessity does not guarantee benefit reimbursement. Benefit reimbursement under the MMHC Program is subject to plan provisions, member eligibility at the time services are rendered, annual deductibles, facility/treatment eligibility and lifetime maximums.

Precertifying Additional Sessions/Days

When you, or a treatment provider/facility, call to precertify in-network care, the mental health plan will certify benefits coverage with a specified start and end date to be paid at the in-network benefit level. If you require additional treatment at the time your precertification for outpatient sessions or inpatient days have been exhausted, or the certification end date occurs, your network provider must contact the mental health plan to certify the additional treatment. It is the responsibility of the network provider to contact the Plan for this process. See "Mental Health Plan Administrator's Clinical Staff and Ongoing Reviews" for more information.

The additional treatment will be reviewed by the Plan to determine continuing medical necessity. If ongoing care is deemed medically necessary, it will be certified by the Plan. Please keep in mind that certification does not guarantee benefits are available; charges will not be paid if benefits are exhausted or if the member is not eligible at the time of treatment.

When the IBM Medical Plan Is Secondary

If you have medical coverage through another group health plan or other coverage and the Plan is secondary to that other coverage, you do not need to precertify mental health/substance abuse care.

Additional Benefits Covered Under the MMHC Program

Service	Benefits
Electroconvulsive Therapy (ECT)	Precertified ECT is covered at the Plan's in-network benefit when received from an in-network provider/facility. If ECT is not precertified, it is subject to retrospective review and out-of-network benefits may apply. **IBM Low, Medium, High Deductible PPO (Inpatient and Outpatient)** In-Network: Facility, Physician, Anesthesia – 80% (70% High Deductible PPO) Out-of-Network: Facility, Physician, Anesthesia – 60% **IBM High Deductible PPO with HSA (Inpatient and Outpatient)** In-Network: Facility, Physician, Anesthesia – 70% Out-of-Network: Facility, Physician, Anesthesia – 55% **EPO** Inpatient – In-Network Facility - $350 copayment per admission; In-Network Physician, Anesthesia – 100% Outpatient – In-Network Facility – 80%; In-Network Physician, Anesthesia – 75%
Marriage and Family Counseling	Marriage counseling is only eligible under the Employee Assistance Program. No reimbursement will be received under the Managed Mental Health Care component of the Plan. Family counseling is eligible under the Employee Assistance Program and eligible for reimbursement under the Managed Mental Health Care component of the Plan.

Service	Benefits
Medication Management Sessions	Medication management sessions are covered at the Plan's in-network benefit when received from an in-network provider. Visits with an out-of-network provider are covered at the Plan's out-of-network benefit. Medication management is not covered under the Employee Assistance Program.
Psychological Testing	Precertified outpatient psychological testing is covered at the Plan's in-network benefit when received from an in-network provider. If outpatient psychological testing is not precertified, it is subject to retrospective review and out-of-network benefits may apply. Outpatient psychological testing received from an out-of-network provider is coverage at the Plan's out-of-network benefit. These services are subject to medical necessity review by the mental health plan upon claims submission. Psychological testing must be rendered by a licensed doctoral-level psychologist (Ph.D.) or with the exception and/or certification of the mental health plan. Psychological testing for developmental, education or learning disabilities is not eligible under the Managed Mental Health Care Program. (Refer to the "Special Care for Children Assistance Program" for possible coverage.)
Psychotherapy	Only one session for psychotherapy per day is eligible for payment under the Plan. When a claim is submitted for psychotherapy provided on an outpatient or an inpatient basis, benefits are payable for up to one session (maximum) for the same service on any given day. A session is defined by the CPT procedure code billed by the provider. Most CPT procedure codes describe the service provided and the amount of time recommended for the session or service. However, benefits are payable for two different services on the same day.
Substance Abuse	Inpatient substance abuse treatment (including alternate levels of care related to substance abuse) is limited to 60 days per lifetime (combined in- and out-of-network).
Technology-Enabled Sessions	Psychotherapy sessions provided via telephone, video conference, Skype, or other mobile technology, is not a covered benefit under the Managed Mental Health Care Program without the prior approval of the administrator.

* There is no out-of-network coverage for the IBM EPO option.

MMHC Emergency Care Coverage

In the event of a mental health emergency, you should call 911 or immediately go to the nearest emergency room. You, or your representative such as a family member or friend, must present your medical plan ID card to identify yourself as a Plan participant. In an emergency, a network hospital must seek certification of the care within 48 hours. If you go to an out-of-network hospital, either you or your attending physician's office, or your representative such as a family member or friend, must call the Clinical Referral Line to seek certification of care within 48 hours.

Failure to notify the mental health plan administrator of a mental health/substance abuse admission for out-of-network facilities will result in an additional $150 penalty and medically necessary care will be reimbursed at the out-of-network benefit. In addition, you will be responsible for all charges for care deemed not medically necessary by the Plan.

How Emergency Is Defined

"Emergencies" are defined as severe psychiatric or substance abuse conditions which render you incapable of providing accurate benefits information at the time of admission to the hospital or incapable of following the provisions of the Plan. The mental health Plan will authorize benefit coverage for hospital admissions deemed medically necessary by the Plan.

In these severe situations, administering appropriate treatment should occur immediately to ensure safety prior to determining whether care is eligible under the Plan.

Out-of-Network Emergency Care

Care at an out-of-network hospital will be certified as "in-network" during the stabilization period for an emergency admission *only* following notification and if the patient accepts a transfer to a network facility after the patient has been stabilized. If the patient does not accept the transfer to an in-network facility/treatment program, benefits will be paid at the out-of-network rate if care is determined to be medically necessary and if the facility meets the eligibility criteria of the Plan.

MMHC Alternate Levels of Care

Alternate levels of care may be approved by the mental health plan in lieu of inpatient treatment as clinically-appropriate and cost effective. Alternate levels of care include residential treatment, group homes, halfway house, partial hospitalization or intensive outpatient treatment.

Note: Wilderness programs, therapeutic schools, and non-medical facilities or their component services are not eligible for reimbursement under the IBM Plan nor are they eligible for alternate level of care.
If an alternate level of treatment care is proposed, the mental health plan administrator will:

- Determine if an alternate level of care is medically necessary.
- Determine if alternate care is a clinically appropriate alternative to hospitalization.
- Approve an appropriate facility that meets the credentialing criteria for in-network reimbursement.

If You Receive An Alternate Level of Care In This Setting	You May Use This Number of Treatment Days/Visits to Equal One Inpatient Day
Residential Treatment	1.5 days
Day Treatment/Partial Hospitalization	2 days
Structured Outpatient	5 days
Sober Living/Transitional Living/Halfway House	10 days
Outpatient Psychotherapy	6 visits

Alternate Levels of Care

To be eligible for the highest level of reimbursement under the IBM Low Deductible PPO, Medium Deductible PPO, High Deductible PPO, IBM High Deductible PPO with HSA options, alternate levels of care must be precertified and must receive case management review by the mental health plan administrator. Alternate levels of care are counted toward annual and lifetime maximums and are subject to the inpatient deductible.

If you seek an alternate level of care out-of-network, you must obtain precertification from the Plan prior to the admission. If you do not notify the Plan, benefits will be paid at the out-of-network level of benefits and you will also be responsible for an additional $150 penalty. Please note that precertification does not guarantee that care is medically necessary. Care is subject to review by the mental health plan administrator upon claims submission. You or your facility is responsible for sending medical records for review by the mental health plan administrator to determine medical necessity.

Alternate Levels of Care under the IBM EPO Option

For any reimbursement under the IBM EPO option, alternate levels of care must be precertified and must receive case management review by the Plan.

If Medicare Is Your Primary Coverage

For Medicare-eligible dependents of non-Medicare-eligible retirees, in order to receive the highest level of reimbursement, the facility/provider must accept Medicare and be in the Optum network.

If Medicare is your primary coverage you must use providers and facilities that accept Medicare. When you obtain services, such as mental health and/or substance abuse services from a provider or facility that does not accept Medicare, those services are not eligible for any reimbursement under the IBM MMHC plan. Refer to "Coordinating IBM Medical Coverage with Medicare" in the Administrative Information section for more information about coordination of benefits with Medicare.

MMHC Benefit Payment

Benefit payment under the Managed Mental Health Care Program is subject to Plan provisions, annual deductibles, coinsurance, copayments and lifetime maximums.

Annual Deductibles and Copayments for Mental Health/Substance Abuse Treatment

- *I*

  (shared with medical services).
- *I* /substance abuse in-network inpatient care. Coinsurance is also required for outpatient visits. See the "Non-Medicare-Eligible: Mental Health Care Program At A Glance "chart for details.

See "MMHC Precertification" for information about additional deductibles for failure to precertify mental health/substance abuse admissions.

MMHC Lifetime Maximums

- *I*

  network care. The lifetime maximum is $1 million per individual for medically necessary eligible services reimbursed at the out-of-network benefit level (mental health/substance abuse is combined with medical services).
- *I* lifetime maximum for medically necessary in-network care. There is no out-of-network coverage under this Plan option.

MMHC Out-of-Pocket Maximum

Managed Mental Health Care charges apply to the medical out-of-pocket maximum for the IBM Low, Medium and High Deductible PPO, IBM High Deductible PPO w/HSA and IBM EPO options.

Mental Health Plan Administrator

All mental health/substance abuse claim payments and member services are handled by the Managed Mental Health Care Program administrator. As claims payer, the Mental Health Care Program administrator is responsible for:

- All claims processing, including coordination of benefits and application of usual and prevailing rates within industry standards.
- Maintaining the provider network.
- Managing and certifying benefit reimbursement for treatment under the IBM Low Deductible PPO, IBM Medium Deductible PPO, IBM High Deductible PPO, and IBM EPO plan options.
- Managing care to assure appropriateness of treatment.

Mental Health Plan Administrator's Clinical Staff and Ongoing Reviews

The mental health plan administrator employs licensed mental health/substance abuse clinicians to assist you, authorize and manage the ongoing treatment plan for you. The clinical team includes Life Resource Counselors and Care Advocates. The clinical staff does not provide treatment directly to you but rather coordinate, direct and evaluate ongoing care. The clinical staff help you navigate the mental health/ substance abuse health care system, continue to provide you with guidance and have ongoing contact with providers and facilities who deliver care to ensure adherence to current treatment plans.

The clinical team employed by the administrator will contact you to discuss treatment, and assist in identifying other services covered under the IBM benefit plans that may be appropriate for you (e.g. financial counseling, legal services, medical referrals, etc.) Also, you are encouraged to contact the clinical team should you have any concerns you wish to discuss. The clinical team will communicate with your provider periodically to assess progress toward stated goals and need for continuing care for all in-network care. Care will continue to be certified in segments at the appropriate level for the length of time it is determined to be medically necessary and clinically appropriate by the administrator.
Out-of-network care is subject to medical necessity review by the mental health plan administrator. You will be responsible for 100% of charges for treatment determined not to be medically necessary, or for care rendered at an ineligible facility.

Care will not be paid by the Plan if it does not meet criteria for precertification, if you are not eligible under the MMHC benefit at the time services are rendered or if benefits are exhausted.

Confidentiality

The mental health plan administrator maintains the confidentiality of all patient-specific clinical information received from patients, their family members and their health care providers. Confidential information will not be disclosed to IBM or others without your express written consent except when required by law or to a third party contracted by IBM to review the program practices, including its clinical records to evaluate the administrator. When the employee or their dependents utilize their mental health benefit, the member who uses services will receive copies of letters, which certify or deny reimbursement and the employee will receive copies of claims explanation of benefits/payment.

If you contact IBM with a concern about a claim or an appeal, IBM must have access to the relevant information necessary to review the concern. In order for IBM to receive information regarding utilization of services and/or treatment, the patient or legal guardian must give written permission to investigate the concern, which means IBM will have the right to review copies of relevant documents generated in response to a certification request or benefit claim (e.g., certification letters and forms, denial letters and Explanation of Benefits [EOB] statements). For information about appealing denied benefits, see "Appeals" in the Legal Information section.

RELATIONSHIP TO THE IBM SPECIAL CARE FOR CHILDREN ASSISTANCE PLAN

The IBM Special Care for Children Assistance Plan is a separate program focused on the developmental problems of children with mental, ph l, or developmental disabilities. The Managed Mental Health Care Program focuses on the treatment of diagnosed mental health and substance abuse problems. See "IBM Special Care for Children Assistance Plan" for details.

IBM Managed Pharmacy Program

IBM Managed Pharmacy Program

ABOUT YOUR PRESCRIPTION DRUG COVERAGE

The IBM Managed Pharmacy Program is designed to help you control medical costs by providing you and your eligible family members with specially-negotiated prices on prescription medications at participating network pharmacies and through a mail-order service. The IBM Managed Pharmacy Program is administered by CVS Caremark.

IBM's prescription drug program is designed to help you save on out-of-pocket costs when you choose generic over brand name drugs, an effective way to slow the rise in prescription drug costs.

When you buy prescription drugs, you will pay a percentage of the cost, up to a per-prescription maximum dollar limit. Limits vary by plan option under the Plan and whether you purchase a generic or brand-name drug. If your doctor prescribes medicines from a list of preferred brand-name and generic medications, called the Formulary Drug List, you will pay a lower percentage of the cost than if you purchase non-formulary drugs. There is no annual deductible under the IBM Managed Pharmacy Program except for those enrolled in the IBM High Deductible PPO with HSA Option.

The eligibility of a prescription medication is subject to the terms of the IBM Managed Pharmacy Program, whether purchased at a participating or non-participating pharmacy. Covered and excluded medications under the Managed Pharmacy Program are defined later in this section.

There are four ways to purchase prescription drugs:

- At a CVS Caremark participating retail pharmacy
- At a non-participating retail pharmacy
- Through the CVS Caremark mail order pharmacy and
- Through a CVS Caremark retail pharmacy under Maintenance Choice®

IBM continues to offer *GenericsAdvantage*, which is designed to help you take advantage of cost-saving alternatives to brand-name prescription drugs.

- If you fill a new prescription with a brand-name drug when a generic with the identical active ingredient (called a generic equivalent) is available, you will pay the generic coinsurance plus the difference in cost between the brand-name drug and the generic drug. (The per prescription maximum will not apply as it usually would for CVS Caremark participating pharmacies and mail-order prescriptions.) This additional cost will apply even if your doctor has indicated "DAW" ("dispense as written") on the prescription.
- If your doctor believes that there is a medical reason for you to use the brand-name drug instead of the generic and if you want to avoid paying the additional cost, your doctor can request a review by calling 800-294-5979, Monday through Friday, 9:00 a.m. to 7:00 p.m., Eastern Time. If the review is approved, you will pay the usual brand-name coinsurance, not the difference in cost.

IBM MANAGED PHARMACY PROGRAM ADMINISTRATOR

The IBM Managed Pharmacy Program is administered by CVS Caremark.

Customer Service Availability
Representatives are available to assist you with claim questions or other inquiries 24 hours a day, 365 days a year. You can reach CVS Caremark Customer Care at 855-465-0030 TTY: 800-863-5488. The CVS Caremark website is www.Caremark.com.

For the fully-insured HMOs, the health plan is the administrator for prescription drug benefits.

WHO IS ELIGIBLE

Non-Medicare-eligible retirees and their eligible dependents, and non-Medicare-eligible dependents of Medicare-eligible retirees (as described in "Eligibility" in the Personal Benefits Program section of this summary plan description) enrolled in one of the following plans are eligible for coverage under the IBM Managed Pharmacy Program:

- IBM Low, Medium and High Deductible PPO options
- IBM High Deductible PPO with Health Savings Account
- IBM EPO

Retirees enrolled in an HMO, the Aetna Medicare Plan (PPO), and the Aetna Medicare Plan (HMO) are not eligible for the IBM Managed Pharmacy Program.

ID Card

If you are eligible for the IBM Managed Pharmacy Program, you will receive a separate ID card for prescription drug coverage. The ID card contains a unique member ID number -- which is not your Social Security number. This card should be used when purchasing drugs from participating retail pharmacies or through the CVS Caremark mail order pharmacy, when calling Customer Care or accessing the CVS Caremark web site. You will receive a second ID card if any family members are enrolled under your medical coverage.

The IBM Managed Pharmacy Program ID card will be in the name of the primary covered person. In most cases this will be the non-Medicare-eligible retiree. Exceptions are ID cards for the IBM EPO – HealthPartners, non-Medicare-eligible dependents of Medicare-eligible retirees, and surviving spouses.

IBM MANAGED PHARMACY PROGRAM AT A GLANCE

Coverage for Non-Medicare-Eligible Retirees

The following chart shows what you pay for prescription drugs:

	IBM Low Deductible PPO and IBM Medium Deductible PPO Benefits	IBM High Deductible PPO Benefits	IBM High Deductible PPO with HSA Benefits**	IBM EPO Benefits
Participating Pharmacies - For up to a 30 day Supply (up to three fills)				
Generic	35% of discounted cost, up to $35	50% of discounted cost	20% of discounted cost after deductible, up to $25	20% of discounted cost, up to $25
Formulary Brand-name	35% of discounted cost, up to $70*	50% of discounted cost	20% of discounted cost after deductible, up to $50*	20% of discounted cost, up to $50*

	IBM Low Deductible PPO and IBM Medium Deductible PPO Benefits	IBM High Deductible PPO Benefits	IBM High Deductible PPO with HSA Benefits**	IBM EPO Benefits
Non-Formulary Brand-name	60% of discounted cost, up to $140*	50% of discounted cost	45% of discounted cost after deductible, up to $100*	45% of discounted cost, up to $100*
Claim Forms	Claim Forms Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.	Claim Forms Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.	Claim Forms Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.	Claim Forms Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.
Non-Participating Pharmacies - For up to a 30 day Supply (up to three fills)				
Generic	45% of actual cost***	50% of actual cost***	30% of actual cost after deductible***	30% of actual cost
Formulary Brand-name	45% of actual cost***	50% of actual cost***	30% of actual cost after deductible***	30% of actual cost
Non-Formulary Brand-name	70% of actual cost***	50% of actual cost***	55% of actual cost after deductible***	55% of actual cost
Claim Forms	You must file a claim	You must file a claim	You must file a claim	You must file a claim
CVS Caremark Mail Service, Specialty Pharmacy or Maintenance Choice - For up to a 90-day supply				
Generic	35% of discounted cost, up to $35	50% of discounted cost	20% of discounted cost after deductible, up to $25	20% of discounted cost, up to $25
Formulary Brand-name	35% of discounted cost, up to $70*	50% of discounted cost	20% of discounted cost after deductible, up to $50*	20% of discounted cost, up to $50*
Non-Formulary Brand-name	60% of discounted cost, up to $140*	50% of discounted cost	45% of discounted cost after deductible, up to $100*	45% of discounted cost, up to $100*
Claim Forms	Claims filed automatically	Claims filed automatically	Claims filed automatically	Claims filed automatically
Annual Benefit Maximum				
Annual Benefit Maximum	Low Deductible: No limit Medium Deductible: $2,500	$1,000	No limit	No limit

* Generics Advantage: If a generic equivalent is available and you choose the brand name drug instead, you will pay the full generic coinsurance (20% with no copay maximum) PLUS the cost difference between the generic and brand name drug.

** High Deductible PPO with HSA cost information: You pay 100% of the cost until you satisfy the Plan's shared medical annual deductible or the family deductible (if more than one person is enrolled in this option). Amounts paid out-of-pocket apply to the medical out-of-pocket maximum. Preventive drugs are not subject to the deductible.

*** Benefits for prescription drugs purchased at non-participating pharmacies count toward the plan's $1 million per person lifetime benefit maximum.

IBM HIGH DEDUCTIBLE PPO WITH HSA PREVENTIVE DRUG BENEFIT

The IBM High Deductible PPO with HSA has a preventive drug benefit. Enrollees in this option will pay the usual coinsurance for preventive medications (those used to prevent a condition from occurring), even if the plan's deductible has not been met. The list of drugs considered preventive for the plan options is available online at www.Caremark.com or by calling CVS Caremark Customer Care. Medications covered as part of the preventive drug benefit follow the guidelines set by the US Preventive Services Task Force.

Medicare Part D Creditable Coverage (Only for Those Enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) as of August 1, 2013)

En llment in a Medicare Part D prescription drug plan is voluntary. IBM has determined that many plan options under the Plan that provide prescription drug benefits meet Medicare's "creditable coverage" standard. This means that for those options, IBM's coverage, on average for all plan participants enrolled in one of those plan options, is expected to pay out as much as the standard Medicare Part D prescription drug coverage. See "IBM Notice of Creditable Coverage" in the Administrative Information section.

The following IBM plan options under the Plan provide creditable coverage in 2015:

- IBM Low and Medium Deductible PPO options
- IBM EPO option
- IBM High Deductible PPO with HSA
- Aetna Medicare Plan (PPO)
- Aetna Medicare Plan (HMO)

Enrollment in a Medicare Part D prescription drug plan is voluntary. You do not need to enroll in a Medicare Part D plan if you are enrolled in an IBM pla le coverage. The Plan will *not* coordinate with Medicare Part D plans, so you should not enroll in both a plan option that provides prescription drug coverage and a Medicare Part D prescription drug plan. This is true even if you enroll in Medicare Parts A and B. See "Coordination of Benefits with the IBM Plan and Medicare" in the Administrative Information section for more information.

RETAIL PHARMACY PROGRAM

You may purchase up to a 30-day supply of covered medication from a participating or non-participating retail pharmacy. You can fill prescriptions for long-term medications up to three times at a retail pharmacy -- your initial prescription plus two refills, or a total of three fills on your current prescription. This is not an annual limit. After that, you generally must order your prescription through the mail-order program or pay 100% of the cost yourself.

Under CVS Caremark's Maintenance Choice program, participants are able to choose to receive their 90 day prescriptions for maintenance medications through the mail or at one of the CVS Pharmacy locations nationwide for the same price as mail order. Note: This option is only available at CVS retail pharmacy locations.

Medications that are exempted from the mail-order program requirement are Schedule 2 Controlled Substances, such as narcotics or drugs used to treat Attention Deficit Disorder, and compound medications. These types of medications can be purchased at a retail pharmacy even if you take them on a long-term basis, subject to the 30-day limit. Patients in nursing homes are also exempt from the mail-order program requirement. However, you must contact CVS Caremark to establish the exemption.

A NOTE ABOUT FORMULARY DRUGS

You will pay a lower percentage of the cost if your doctor prescribes a medication from this list of preferred drugs. You'll still be able to purchase non-preferred brand name medications but you will pay a greater share of the cost. You can obtain a current formulary list on www.Caremark.com. For more details, see Formulary Drug List.

Participating Network Pharmacies

CVS Caremark contracts with a large network of chain and independent pharmacies across the United States. These pharmacies agree to accept specially-negotiated prices on prescription drugs. When you and your eligible family members use a participating pharmacy and show your pharmacy ID card, there are no claim forms to file. All you have to do is pay your portion of coinsurance. There is no annual deductible under the IBM Managed Pharmacy Program unless you are enrolled in the IBM PPO with HSA, IBM PPO Plus with HSA option. When you use a participating pharmacy, benefits do not apply to the annual out-of-pocket medical plan maximum.

To find a participating pharmacy in your area, log in to www.Caremark.com or call CVS Caremark Customer Care. Individuals who reside in an area without convenient access to a network pharmacy can ask their pharmacist to call CVS Caremark Customer Care to get information about joining the network.

How to Fill Your Prescription Under the Retail Program

When you need to fill a prescription at a participating retail pharmacy, simply follow these steps:

- Present your ID card to the pharmacist before the prescription is dispensed to ensure that your claim will be processed automatically and that you will be charged the correct coinsurance amount.
- Pay the pharmacist for your portion of the prescription at the time of purchase.
- If you fill a new prescription with a brand-name drug when a generic with the identical active ingredient (called a generic equivalent) is available ll pay the generic coinsurance plus the difference in cost between the brand-name drug and the generic drug. This additional cost will apply even if your doctor has indicated "DAW" ("dispense as written") on the prescription.

If You Don't Use Your ID Card at a Participating Pharmacy

If you do not show your ID card at a participating pharmacy, you will pay for the prescription in full and submit a claim form to CVS Caremark for reimbursement. Your reimbursement will be based on the negotiated price for the applicable type of medication (generic/formulary brand-name or non-formulary brand-name) and *not* the price you paid. You may ask the pharmacist to contact CVS Caremark to confirm your eligibility. To file a claim, follow the directions under "How to File a Claim for Non-participating Pharmacies".

Non-Participating Pharmacies

If you choose to have a prescription filled at a pharmacy that does not participate in CVS Caremark's network (a non-participating pharmacy), you must pay 100% of the pharmacy's actual charge at the time you receive your medication. You then file a claim for reimbursement. If you use a non-participating pharmacy, you will only be reimbursed up to a 30-day supply, even if you purchase a larger supply. Your claim will be processed within 30 days from the date your claim form is received.

If you use an out-of-network pharmacy to purchase your medically necessary medications, your benefits will be applied toward the $1 million individual out-of-network lifetime maximum under the IBM Low, Medium and High Deductible PPOs.

How to File a Claim for Non-participating Pharmacies

Complete a claim form, attach a prescription receipt to the form and mail it to the address on the form. Keep in mind that the prescription receipt *must* be attached to your claim form in order for the claim to be processed. You may obtain a claim form from CVS Caremark, NetBenefits or the ESC.

MAIL ORDER PHARMACY PROGRAM

The CVS Caremark's Mail Order Pharmacy home-delivery program provides a convenient, cost-effective way to purchase long-term prescription medications. If you have a chronic condition, such as high blood pressure, high cholesterol, heart conditions, arthritis, ulcers, asthma and diabetes, you should use the mail program to purchase your long-term prescriptions. Through the mail-order program, you may receive up to a 90-day supply of the prescription medication. Orders will be delivered by mail, postage paid, anywhere in the United States. You can request expedited shipping (for an additional fee) at the time you place your order.

Please note that you can use the CVS Caremark Mail Order pharmacy in order to receive up to 90 days of medication or Maintenance Choice. All other mail service programs, such as AARP and online pharmacies, will be treated as retail pharmacies and only 30 days will be reimbursed, even if you purchase a greater quantity.

IF YOU TRAVEL OR RESIDE OUTSIDE THE U.S.

If you are planning on being out of the country for an extended period of time and you need an additional supply of medications before you leave the country, the Managed Pharmacy Program allows for a vacation supply of medication (up to 60 days through retail and 180 days through the mail program). Additional supplies beyond 60 days are only covered through the mail-order program. If you are using the mail-order program for the first time, you should allow for up to 14 days for delivery after receipt of your prescription by the mail-order pharmacy.

There are no participating pharmacies located out-side the U.S. Therefore, if you purchase medications while outside the U.S. you must submit a claim to receive reimbursement and will be subject to the non-participating pharmacy level of reimbursement. Drugs purchased outside the U.S. must have an exact American equivalent to be eligible for reimbursement.

Retirees living overseas are eligible to be reimbursed for up to a 90-day supply purchased at retail pharmacies overseas at in-network levels.

How to Order New Prescriptions

- If you need your prescription immediately, ask your physician to write two prescriptions — one for a 14-day supply to be filled at your retail participating pharmacy and a second to be filled by the Mail Order Pharmacy for up to a 90-day supply with three refills.
- Your doctor may fax the prescription directly to the Mail Order Pharmacy (call CVS Caremark Customer Care for instructions on how your doctor can fax the prescription). Be sure your doctor has your Member ID number, which can be found on your ID card. If your doctor faxes in your prescription, CVS Caremark will bill you for your coinsurance unless you are set up for automatic payment.
- Or, you may mail your original prescription or refill slips together with the completed order form and required payment to the Mail Order Pharmacy. If you mail more than one prescription in the same envelope, be sure to include the correct coinsurance amount for each. Order forms and envelopes are available from CVS Caremark Customer Care.

- Your mail account balance cannot exceed $300. Once you reach this limit, medications will not be shipped until you pay your balance.
- CVS Caremark will promptly process your order and send your medications, along with your invoice, to your home within approximately 14 days through U.S. Mail or United Parcel Service (UPS) along with instructions for refills. Medications requiring special handling will be shipped in accordance with established safety and security procedures. A signature may be required for certain medications. Check with CVS Caremark Customer Care at the time you order.

How to Order Refills

- You may reorder your prescription on or after the refill date indicated on the refill slip of your medication container or when you have used 75% of your medication. At no time can you refill if you have more than 30 days of medication on hand (m). You may order refills online through www.Caremark.com, by phone or by mail. You'll need your Member ID number, the prescription number, your credit card number and the expiration date to order a refill.
- To determine the amount of your payment, you can call CVS Caremark Customer Care or log in to www.Caremark.com.
- You will need to provide the number of days' supply, dosage, strength, exact drug name and quantity.

Paying for Prescriptions Through the Mail-Order Program

You may pay your coinsurance by check, credit card, debit card, money order, e-check or IBM Health Savings Account Debit Card (be sure to sign the mail order form if paying by credit card). If your physician faxes the prescription to the Mail Order Pharmacy on your behalf, CVS Caremark will bill you later for your coinsurance unless you set up automatic payment. Note that if you have an outstanding mail account balance of $300 or more, CVS Caremark cannot ship your medication until you pay your balance. To set up automatic payment, simply provide your credit or debit card number on the mail order form and complete the applicable information.

COMPOUND MEDICATIONS

Please note when purchasing a compound medication, claims are adjudicated using a different formula. Please contact CVS Caremark for specific details.

If you submit a paper claim for one of these medications, you will need to include an itemized list of each ingredient including its name, National Drug Code, price and quantity used. Formulary and non-formulary reimbursement levels apply. Formulary status is determined by the status of the largest component in the compound. There is a separate Compound Claim Form available from CVS Caremark.

Beginning January 1, 2015,
- all compound prescriptions (both in- and out-of-network) greater than $500 in cost will require prior authorization
- costly proprietary topical compounding bases and bulk powders (that have not been proven to have additional benefits) will be excluded from coverage
- coverage for compounds will be limited to 30-day supplies

Beginning September 1, 2015,
- all compound prescriptions (both in- and out-of-network) greater than $300 in cost will require prior authorization

If the compound ingredients are not covered, you will be responsible for the full cost of the prescription. If the compound ingredients are covered through prior authorization, you will pay your usual cost share. This is particularly important to remember if the compounding pharmacy suggests you pay out-of-pocket for compounded prescriptions, then submit the claim through your benefit plan for reimbursement. Please be aware that these claims also will be subject to review, and reimbursement is not guaranteed.

CVS CAREMARK MAINTENANCE CHOICE®

Maintenance Choice® is a feature of the IBM Managed Pharmacy Program. You can continue to have your 90-day supply of medications shipped directly to your home, or you can pick them up at your local CVS/pharmacy for the same coinsurance. The choice is yours.

All of the medications, with an 84 - 90 day supply that you currently order through mail service are eligible for this program.

If you take several long-term medications, you have the flexibility to receive some through mail and others at retail pick-up through your local CVS/pharmacy. You can transfer your mail-service prescriptions to your local CVS/pharmacy by calling Customer Care at 855-465-0030 or signing on to www.Caremark.com.

If you need to obtain a new prescription, you can have the pharmacist at your local CVS/pharmacy contact your doctor for a 90-day prescription. You can also ask your doctor to call the CVS/pharmacy location with a 90-day prescription. Let the pharmacist know that your prescription benefit program includes the Maintenance Choice® feature.

Please note: some medications may not be eligible for 90 day supplies through Maintenance Choice due to state regulations, such as Schedule 2 Controlled Substances (e.g., narcotics or drugs used to treat Attention Deficit Disorder). Contact CVS Caremark Customer Care for more details.

COVERED MEDICATIONS

The following items are covered when prescribed by a physician and medically necessary:

- Federal legend drugs
- State restricted drugs
- Compounded medications of which at least one ingredient is a legend drug; (Note: new coverage rules apply; please see Compound Medications for details)
- Oral contraceptives, the contraceptive patch (Ortho EVRA), contraceptive devices and implants; contraceptive jellies, creams and foams with a prescription (Note: Contraceptive devices and implants not available through the IBM Managed Pharmacy Program may be covered under the IBM Medical Plan.)
- Insulin
- Needles and syringes
- Certain over-the-counter diabetic supplies with a prescription
- Retin-A and Avita cream through age 34 (may be eligible beyond age 34 with prior authorization)
- Legend prenatal vitamins
- Legend vitamin D and K
- Legend folic acid
- Hematinic vitamins and
- Legend vitamin B12/Cyanocobalamin.

Exclusions Under the Managed Pharmacy Program

- Non-federal legend drugs
- Contraceptive jellies, creams or foams)
- Topical fluoride products

- Anabolic steroids
- Yohimbine
- Allergy sera
- Therapeutic devices or appliances
- Drugs which are not considered medically necessary
- Drugs whose sole purpose is to promote or stimulate hair growth (for example, Rogaine, Propecia) or drugs for cosmetic purposes only (for example, Renova)
- Immunization agents and vaccines
- Biologicals, blood or blood plasma
- Drugs labeled "Caution -- limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows it to be operated on its premises, a facility for dispensing pharmaceuticals (covered under the IBM Medical Plan)
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- Medical devices and appliances
- Vitamins and minerals — except the following, which are covered: hematinics for the treatment of anemia, prenatal vitamins, legend folic acid, legend vitamin B12/Cyanocobalamin and legend vitamin D and K
- Over-the-counter medications, even when prescribed (except for certain diabetic supplies)
- Certain over-the-counter, non-essential medical supplies, including alcohol wipes and insulin pump batteries. For a complete list of excluded supplies, please contact CVS Caremark Customer Care
- Any other exclusions listed under "Exclusions: What the IBM Medical Plan Does Not Cover"
- Homeopathic, naturopathic treatments, minerals, nutritional supplements, dietetic foods, etc.
- Prescription drugs for which there is an over-the-counter equivalent available in the same strength and preparation, such as meclizine and ranitidine (Contact CVS Caremark Customer Care for a complete list)
- Drugs purchased in foreign countries which do not have an exact American equivalent and
- All medications in the Proton pump inhibitor class (generic and brand-name), such as lansoprazole, omeprazole, pantoprazole, Aciphex, Dexilan, Nexium and Zegerid for patients 18 years of age and older
- Bulk chemicals which have not been determined to be safe and effective or medically necessary for topical administration (Contact CVS Caremark Customer Care for a complete list)

FORMULARY DRUG LIST

The IBM Managed Pharmacy Program includes a formulary feature. A formulary is a list of commonly prescribed medications that have been shown to be clinically effective as well as cost effective. If your doctor prescribes formulary medications, you can help control rising health care costs while still maintaining high-quality care.

You can obtain the Formulary Drug List online at www.Caremark.com or by calling CVS Customer Care. When a generic equivalent becomes available for a brand medication, that brand medication is automatically removed from the formulary. Because the formulary list is subject to change, you should consult CVS Caremark before filling a prescription to ensure you have the most current information.

If you choose to purchase a brand medication not on the formulary, you will be responsible for paying a higher coinsurance. If there is a clinical reason why you cannot take the formulary medication, you can request an appeal through CVS Caremark by calling Customer Care. If the appeal is approved, you will only be charged the formulary coinsurance. This approval is valid for as long as you are taking the prescription.

Under the IBM Managed Pharmacy Program there may be times when you use a participating pharmacy and are filling a prescription with a non-formulary brand-name drug. The pharmacist will receive a message stating the status of the medication is non-formulary. Your retail pharmacist may decide to discuss with your physician whether an alternative drug listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. If you prefer to have the originally-prescribed medication, you have the option to refuse the alternative medication prior to it being filled and to request the pharmacist fill the prescription as it was originally written. However, you will be responsible for paying the higher, non-formulary brand-name coinsurance.

When you order through the mail-order program, the pharmacist may also decide to discuss with your physician whether an alternative medication listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative medication and a confirmation letter will be sent to you and your physician explaining the change.

Let your physician know if you have any questions about a change in prescription. Your physician always makes the final decision about what medication to prescribe for you.

GENERIC DRUGS

Generic-equivalent medications contain the same active ingredients and are subject to the same rigid Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs because they don't require the same level of sales, advertising and development which are expenses associated with brand-name drugs.

Under the IBM Managed Pharmacy Program, CVS Caremark will periodically review medications and if there is a generic available for the brand-name medication you are currently using, you may receive a letter advising you of the generic availability.

This is a voluntary program and if you prefer to continue using the brand-name drug you may do so. Your doctor should write Dispense as Written (DAW) on the prescription to prevent a switch being made. Please note the specifics of this requirement may vary by state. Check with your doctor. If you switch to a generic medication your coinsurance will be based on the generic price. If you remain on the brand name drug, your coinsurance will be based on the GenericsAdvantage cost share provisions described previously.

Starting January 1, 2014, for certain therapeutic classes, you may be required to try generic medications before the plan covers more expensive brand-name alternatives. This will apply even if you have been taking the brand-name medication for some time. Please contact CVS Caremark Customer Care for a complete list of drugs in this Generic Step Therapy Program.

If you switch to a generic medication your coinsurance will be based on the generic price. If you choose to stay on the brand-name medication, you will have to pay the medication's full price if you have not tried the generic option(s) available to treat your condition. If your doctor feels you have a unique medical situation that requires you to keep taking the brand-name medication, ask him or her to call CVS Caremark at 877-203-0003 to request prior authorization.

Please note for all brand-name drugs not on the Generic Step Therapy Program list, unless your doctor writes "Dispense as Written" on your prescription, state laws may permit the pharmacist to substitute, or may require the pharmacist to substitute, a generic version of the prescribed drug if all prescription requirements are met.

DRUG MANAGEMENT PROGRAMS

Prior Authorization Program

The IBM Managed Pharmacy Program provides coverage for some medications only if they are prescribed for certain uses. These medications must receive "prior authorization" before they can be covered under the IBM Managed Pharmacy Program. The list of drugs requiring prior authorization changes periodically. If you have a question on drug coverage, please call CVS Caremark Customer Care.

If you require a new prescription for a specialty medication, your doctor will fi lies with standard clinical guidelines. This requirement will help ensure you receive the proper drug, dose and treatment based on your diagnosis.

If the medication prescribed for you requires prior authorization, ask your physician to call the Authorization Unit at CVS Caremark for instructions on how to initiate the review process. You can obtain the phone number by calling CVS Caremark Customer Care. Otherwise, if you take a prescription for one of these medications to a participating pharmacy without prior approval, the pharmacist can initiate the review process on your behalf ll provide you with the telephone number for your doctor to call. This process typically takes two business days to complete. You and your physician will be notified by mail when the review process has been completed.

If your medication is not approved for coverage under the IBM Managed Pharmacy Program, you will be responsible for paying the full cost of the drug.

CVS Caremark Specialty Pharmacy

If you need covered prescription medications that require special handling or administration, like chemotherapy drugs, and are currently receiving these medications through your doctor's office or other treatment center, you will need to order them through CVS Caremark Specialty Pharmacy, part of the IBM Managed Pharmacy Program. By receiving covered prescription medications this way, you may pay less for them overall. Additionally, you may be able to have them shipped directly to you or your doctor's office at no additional charge. Contact CVS Caremark Specialty Customer Service at 800-237-2767 to transfer a prescription or obtain more details.

Note: specialty drugs purchased at a retail pharmacy will not be covered. All specialty drugs must be obtained through the CVS Caremark Specialty Pharmacy except as follows:

- Specialty medications provided by your medical provider that are billed as part of your office visit, will still be covered
- If a medication's manufacturer has an exclusive arrangement with a specialty pharmacy other than CVS Caremark, that pharmacy will fulfill your medication instead of CVS Caremark Specialty Pharmacy and you will have coverage under the Plan.

In addition, CVS Caremark's Specialty Drug Step Therapy program promotes the use of safe, equally effective, and lower-cost preferred medications before using a higher-cost, non-preferred medication. You will be required to try the preferred medication first. If you decide to take the non-preferred medication without trying the preferred, you will have to pay the full price for the non-preferred medication. This rule covers drugs to treat rheumatoid arthritis, multiple sclerosis, and infertility and applies to individuals who start taking such medications on and after January 1, 2014. Participants who started taking these medications in the last six months of 2013 or earlier are not affected.
Keep in mind, some specialty medications require a cli l review to be used for continued treatment or when they are first prescribed. Contact CVS Caremark Customer Care for more information.

Effective January 1, 2014, the IBM Managed Pharmacy Program is implementing CVS Caremark's Specialty Guideline Management Program. For continued coverage of a medication in this program, a clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review. There is a chance the review will identify other options for treating your condition. If so, you and your doctor will be notified.

Dose Optimization Program

Certain long-term medications will be covered by the IBM Managed Pharmacy Program's dose optimization feature, which makes prescriptions availa

It in greater convenience and lower costs for participants. CVS Caremark will contact your doctor and ask if dose optimization is right for you. If your doctor approves, you will receive the optimized dose.

Drug Utilization Review — Safe and Appropriate Use of Medications

By continually using participating pharmacies or by using the mail-order pharmacy, you also gain the advantage of a prescription review. This confidential online system allows the pharmacist access to important information, such as your individual drug history, the possibilities of interaction among various drugs and how long it has been since your last prescription was filled. If the potential for drug-related illness or incompatibility is flagged, an alert message is sent to the pharmacist who can then inform you to check with your doctor or make a professional judgment whether to dispense your prescription.

Under the IBM Managed Pharmacy Retail Program there is a "refill-too-soon" feature which does not allow a refill of medication until 75% of the original prescription has been used. This feature helps to prevent overuse of medication and purchase of more medication than is necessary. Additionally, under the mail-order program your refill slip will indicate your earliest refill date. If you request a refill prior to the earliest refill date, your refill request will be held and sent on the appropriate refill date.

There is also a coverage management program which has established appropriate threshold levels of utilization (e.g. limit on number of doses) for specific drug therapy categories and payment will be rejected at the point of sale (retail or mail) whenever the drugs being dispensed exceed those predetermined limits or if you do not meet the clinical criteria to receive the medication (determined by the prior authorization review).

COORDINATION OF BENEFITS

It is a requirement under the Plan to provide information regarding any other coverage they may have. If there is an indication that there is other primary coverage, payment in full will be required at the time of purchase from a retail pharmacy and from the mail-order program. You must first file a claim with the primary plan. When you receive the Explanation of Benefits (EOB) statement from the primary plan, fill out the IBM Managed Pharmacy Claim Coordination of Benefits/Out-of-Network Claims form and attach a copy of the EOB and your receipt and mail these documents to CVS Caremark at the address on the form. Your claim will be processed according to the Plan's coordination of benefits provisions. See "Coordinating Coverage" in the Administrative Information section.

If the primary coverage is also a card program, you should attach your receipt to a copy of the claim form and mail to CVS Caremark for consideration of any additional benefit.

Special rules apply for coordination with Medicare Part D prescription drug plans. See "Coordinating IBM Medical Coverage with Medicare."

OTHER IMPORTANT INFORMATION

Other features of the IBM Managed Pharmacy Program include keeping a profile of your medication history and providing a toll-free number to speak with a pharmacist.

Prescription information of retirees and their dependents is used by CVS Caremark and its affiliates to administer the IBM Managed Pharmacy Program. As part of this administration, CVS Caremark generally reports that information to the administrator of the IBM medical plan option that you selected, and your Medical Plan administrator reports your medical information to CVS Caremark. Your prescription and medical data is used to identify potential overuse, abuse and waste of particular medications as well as appropriateness of the medications prescribed. CVS Caremark may send alerts to prescribing physicians and dispensing pharmacists about the situations it identifies. CVS Caremark also uses the prescription data gathered from claims submitted nationwide for reporting and analysis without identifying individual patients.

CVS Caremark may also take other actions to address concerns it identifies with utilization of the IBM Managed Pharmacy Program, including limiting you to the use of one retail pharmacy if your pattern of utilization for a particular medication warrants it.

IBM Benefits Plan for Retired Employees
IBM Dental Coverage

IBM Dental Coverage

ABOUT YOUR DENTAL BENEFITS

IBM's dental coverage offers you a choice of options, depending on your retirement date and Medicare eligibility status. Your personalized Health Plan Detail Sheets, which you receive during your initial eligibility for the Plan and during subsequent annual enrollment periods, will reflect the options that are available to you, including the Cigna Dental Maintenance Alternative (DMA) option if it is available for your area.

The Dental Coverage section of this summary plan description covers the details of the IBM Dental Option A, Dental Option B, P , IBM Dental Plus and IBM Dental Basic options. To receive detailed information about the Cigna DMA, contact Cigna directly.

The options available depend on the retiree's retirement date and Medicare eligibility status. If you retired or otherwise first became eligible for post-employment benefits under this Plan prior to January 1, 2000 and are not Medicare-eligible, or if you are enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO), your choices for dental coverage are: Dental Option A, Dental Option B, MetLife Preferred Dentist Program (PDP), Cigna Dental Maintenance Alternative (DMA), if available in your area, or you can waive coverage, as explained below.

IBM DENTAL PLAN ADMINISTRATOR
The IBM Dental Plan options are administered by MetLife.

Customer Service Availability
Representatives are available to assist you with claim questions or other inquiries Monday through Friday from 8 a.m. to 110 p.m. Eastern Time. The Voice Response Unit (VRU) for claims inquiries is available 24 hours a day, 7 days a week.

You can reach MetLife at 800-872-6963 (TTY: 800-843-2896) or www.metlife.com/mybenefits.

The Cigna DMA is administered by Cigna. You can reach Cigna at 800-367-5189 (TTY: 800-962-5169) or at www.cigna.com/consumer/services/dental.

If you retired or otherwise first became eligible for post-employment benefits under this Plan on or after January 1, 2000 and are not Medicare-eligible, or if you are enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) as of August 1, 2013, your choices for dental coverage are: IBM Dental Plus, IBM Dental Basic, Cigna Dental Maintenance Alternative (DMA), if available in your area, or you can waive coverage, as explained below.

You can elect "no coverage" for the plan year and pay no contribution. If you waive dental coverage because you have coverage elsewhere, you will not be allowed to request coverage under the Plan during the plan year unless you lose the coverage you had elsewhere as a result of a qualified status change. This could happen, for example, if you were covered under your spouse's employer-sponsored plan, and your spouse loses his or her job.

Who Is Eligible

Retirees who are not Medicare-eligible, their eligible dependents, non-Medicare-eligible dependents of Medicare-eligible retirees or participants enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) as of August 1, 2013 (as described in "Eligibility" in the Personal Benefits Program section of this summary plan description) are eligible to enroll in dental coverage under the Plan.

If you and your eligible family members are living outside of the U.S. and Puerto Rico, you will be eligible for dental benefits reimbursement for eligible services but at the out-of-network level only since there are no network providers outside of the U.S. and Puerto Rico.

Note that once you (and/or your eligible dependent(s)) reach age 65 or become eligible for Medicare, you will no longer be eligible for dental coverage under the Plan. (This does not apply to retirees enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) options. These individuals will still have access to IBM group dental plan options for 2014 and 2015 as long as they choose to remain enrolled in their Aetna plan.)

ID Card

If you enroll in a dental option administered by MetLife, you will receive an ID card, which will remain good for as long as you are enrolled in any dental option administered by MetLife. New cards will not be sent each year. If your card is lost or damaged, call MetLife member services to request a replacement card or log onto www.metlife.com/mybenefits to print one.

Dental Options If You Retired Prior to January 1, 2000 and Are Not Medicare-Eligible or Are Enrolled in Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO)

- **Dental Option A** — This option provides assistance for expenses relating to a full range of services, f llings, root canals and orthodontics. Services are reimbursed according to a fixed fee schedule after you satisfy a $40 annual deductible per covered individual. There is a lifetime maxi-mum of $9,000 per covered individual under this Plan, which includes a $1,500 orthodontia lifetime maximum.
- **Dental Option B** — This option provides assistance for expenses relating only to preventive and di-agnostic services and some basic treatment procedures, such as fillings. Services are reimbursed ac-cording to the same allowance schedule as Dental Option A. There is no annual deductible per covered individual. This Plan is subject to the same lifetime maximum of $9,000 per covered individual. Orthodontia services are not covered under this Plan. Benefits used toward the $9,000 lifetime maximum will be counted even if you elect to change plans and later re-enroll in Option A or Option B.
- **MetLife Preferred Dentist Program (PDP)** —The PDP provides financial assistance toward the expenses of dental care and treatment for preventive, diagnostic, basic and major procedures and orthodontia. The PDP reimburses a percentage of the dentist's negotiated fee when you use a participating dentist, and a fixed amount on limited services for non-participating dentists (same coverage as Dental Option B, Schedule III). There is no annual deductible and no lifetime maximum, with the exception of orthodontics, where there is a $1,500 lifetime maximum.
- **Cigna Dental Maintenance Alternative (DMA) option** —The Cigna DMA covers most routine dental services at 100% and charges you a copayment for more extensive dental procedures. For eligible services to be covered, you must use dentists who are members of the Cigna network. Enrolling in the Cigna DMA is an alternative to IBM dental coverage and you agree to obtain your coverage from Cigna and not from the IBM Plan. If you enroll in the Cigna DMA, you will receive a summary plan description directly from Cigna.

MORE ABOUT THE CIGNA DMA

When you join the DMA you are electing an alternative to IBM dental coverage and agree to obtain your coverage from that organization and not from the IBM Plan.

DMA's service area. Please note if your dentist drops out of the DMA network, you must choose another dentist in the network for the remainder of the year; you may not switch dental options.

IBM's dependent eligibility guidelines pertain to all benefit options under the IBM Personal Benefits Program, including the DMA, and are not subject to any state laws mandating coverage for anyone not included in IBM's list of eligible dependents.

Dental Options If You Retired On or After January 1, 2000 and Are Not Medicare-Eligible or Enrolled in Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO)

- **IBM Dental Basic option** — The Dental Basic option provides a basic level of coverage for preventive, diagnostic and basic restorative care only, up to a $500 annual maximum benefit limit per covered person. If you use an in-network dentist, the Plan covers preventive and diagnostic care at 100% of eligible charges. There is no annual deductible for this option.
- **IBM Dental Plus option** —The IBM Dental Plus option offers you the opportunity to increase your dental benefits to cover more extensive dental treatment, including preventive, diagnostic, basic restorative, major restorative and orthodontia care. Benefits under the Dental Plus option are limited to $2,000 per covered person per year; orthodontia care is limited to a lifetime maximum up to $1,500 per covered person.
- Cigna Dental Maintenance Alternative (DMA) option — See the description above.

Dental Options for Retirees Who Retired Prior to January 1, 2000

Retirees who are not eligible for Medicare, non-Medicare-eligible dependents of Medicare-eligible retirees and those enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) can enroll in the dental plans described below.

IBM DENTAL PLAN OPTIONS AT A GLANCE FOR PRE-2000 RETIREES

	Dental Option A	Dental Option B	MetLife PDP
Annual Deductible	$40 per covered person	None	None
Annual Maximum Benefit	No limit	No limit	No limit
Lifetime Maximum Benefit	$9,000 per covered person Combined for Dental Option A and Dental Option B (includes orthodontia maximum)	$9,000 per covered person Combined for Dental Option A and Dental Option B (includes orthodontia maximum)	No limit (except orthodontia)
Orthodontia Lifetime Maximum	$1,500 per covered person	Not applicable	$1,500 per covered person
Services	▪ Preventive/ diagnostic ▪ Basic restorative ▪ Major restorative ▪ Orthodontia ▪ Dental implants*	▪ Preventive/ diagnostic ▪ Basic restorative	▪ Preventive/ diagnostic ▪ Basic restorative ▪ Major restorative (in-network only) ▪ Orthodontia (in-network only)

* A pre-treatment estimate is required for implants and implant-related services.

HOW THE IBM DENTAL OPTION A AND OPTION B PLANS WORK

The IBM Dental Option A and Option B Plans are available to pre-2000 eligible retirees who are not Medicare-eligible, their eligible family members who are not Medicare-eligible and retirees enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) and their dependents as of August 1, 2013. They provide financial assistance, based on four geographic schedules, toward the expenses of dental care and treatment. Each dental option makes benefit payments as assistance toward actual charges for dental care and treatment up to the amount of the applicable benefit allowance. These allowances apply to eligible services wherever they are performed, such as the dentist's office or the hospital. The most common procedures for each dental option are included in the partial schedules that follow. Additional information not included in these schedules can be obtained from MetLife.

In cases of coordination of benefits, if the primary plan benefit issued is equal to or exceeds the scheduled benefit under the Plan, there will be no payment made by the Plan as secondary coverage.

If a retiree switches plans from Dental Option A to Dental Option B, any dental treatment "in progress" at the time of the retiree's enrollment change will become ineligible for coverage unless the services continue to be eligible under Dental Option B. Also, benefits paid toward the $9,000 lifetime maximum carry over from Dental Option A to Dental Option B, and vice versa, if the retiree changes plans.

Annual Deductible

- **Dental Option A:** Each covered individual must satisfy a $40 annual deductible before Dental Option A pays benefits for covered services. Charges used to satisfy the deductible will not be eligible for reimbursement under any other IBM benefit plan. Each family member must satisfy the deductible once each calendar year.
- **Dental Option B:** There is no annual deductible for Dental Option B.

Lifetime Maximum Benefit

You and your eligible family members may receive benefit payments up to a lifetime maximum of $9,000 for each individual. Benefits paid under both Dental Options A and B contribute to the lifetime maximum. Under Dental Option A, there is a lifetime benefit maximum of up to $1,500 for orthodontic services for each eligible family member, which is included in the overall $9,000 lifetime maximum.

If you, the retiree, reach the $9,000 lifetime maximum under Dental Options A or B, this is considered a qualified status change. You have the option to opt out of dental coverage for the remainder of the plan year and save the monthly contribution. However, you will have to wait until the next annual open enrollment period to select a new dental option (for example, the PDP or CIGNA DMA if available in your area). If you choose to opt out of coverage, any eligible family members you cover will also lose their dental coverage for the rest of the plan year. Also, if dependents reach their $9,000 lifetime maximum, the retiree can drop them from coverage the first of the following month in which the retiree notifies the ESC.

For more information about making a qualified status change, see "Changing Coverage Due to a Qualified Status Change" in the Administrative Information section.

There is no duplication of plan maximums. Lifetime maximums cannot be combined and apply to the dental plan option selected. If you reach your lifetime maximum in one option you cannot enroll in that option again, regardless of the ID number used. You may enroll in another dental option during the next annual enrollment period. If you have a qualified status change and change your enrollment from being primary to being a dependent of your spouse, deductibles do not transfer even you stay in the same plan.

Geographic Areas

The benefit allowance under Dental Option A and Dental Option B is based on specific schedules and reflects differences in dental charges by geographic area. To find scheduled allowances in your area, follow these steps:

- Consult the location lists that follow to determine which schedule applies to your dentist (it is keyed to the dentist's office location where work is provided based on the first three digits of the ZIP Code).

- Refer to the appropriate benefit allowance schedule that follows to determine the benefits that are payable under Option A or B, as appropriate. Note that all foreign claims will be processed according to Schedule III.

Geographic Schedule

Dentist's Office Location	Schedule
Alabama	II
Alaska	IV
Arizona	II
Arkansas	
▪ Little Rock (ZIP Codes beginning with 722 only)	II
▪ Remainder of State	I
California	IV
Colorado	
▪ Denver, Boulder Area (ZIP Codes beginning with 800 – 806)	III
▪ Remainder of State	II
Connecticut	
▪ West (ZIP Codes beginning with 060, 061, 064 – 069)	IV
▪ East (ZIP Codes beginning with 062 – 063	III
Delaware	III
District of Columbia	III
Florida	
▪ Miami, Ft. Lauderdale, Boca Raton (ZIP Codes beginning with 330 – 334 and 349 only)	III
▪ Remainder of State	II
Georgia	
▪ Atlanta Area (ZIP Codes beginning with 300 – 303 only)	II
▪ Remainder of State	I
Guam	II
Hawaii	III
Idaho	II
Illinois	
▪ Chicago Area (ZIP Codes beginning with 600 – 606 only)	III
▪ Remainder of State	II
Indiana	II
Iowa	I
Kansas	II
Kentucky	I
Louisiana	II
Maine	I
Maryland	
▪ Washington, D.C. Area (ZIP Codes beginning with 206 – 209 only)	III
▪ Remainder of State	II
Massachusetts	
▪ Boston (ZIP Codes beginning with 020 – 022 only)	IV
▪ Remainder of State	III
Michigan	
▪ Detroit and Area (ZIP Codes beginning with 480 – 483 only)	III
▪ Flint (ZIP Codes beginning with 485 only)	III
▪ Lansing (ZIP Codes beginning with 489 only)	III
▪ Grand Rapids (ZIP Codes beginning with 495 only)	III
▪ Remainder of State	II

Geographic Schedule

Dentist's Office Location	Schedule
Minnesota	
▪ Minneapolis – St. Paul and Rochester (ZIP Codes beginning with 550, 551, 553, 554 and 559 only)	II
▪ Remainder of State	I
Mississippi	II
Missouri	
▪ St. Louis Area (ZIP Codes beginning with 630 – 633 only)	II
▪ Kansas City Area (ZIP Codes beginning with 640 – 641 only)	II
▪ Remainder of State	I
Montana	II
Nebraska	I
Nevada	III
New Hampshire	II
New Jersey	
▪ Northern New Jersey (ZIP Codes beginning with 070 – 079, 085, 086, 088 and 089)	IV
▪ Remainder of State	III
New Mexico	II
New York	
▪ Westchester, Putnam and Rockland Counties, New York City, Long Island (ZIP Codes beginning with 100 – 119 only)	IV
▪ Albany, Kingston, Poughkeepsie, Buffalo and Rochester Areas (ZIP Codes beginning with 120 – 126 and 140 – 146 only)	II
▪ Remainder of State	I
North Carolina	
▪ Winston-Salem, Raleigh-Durham, Greensboro Area/Charlotte (ZIP Codes beginning with 270 – 277 and 280 – 282 only)	II
▪ Remainder of State	I
North Dakota	I
Ohio	
▪ Cleveland (ZIP Codes beginning with 440 – 441 only)	II
▪ Columbus (ZIP Codes beginning with 430 – 432 only)	II
▪ Dayton (ZIP Codes beginning with 453 – 454 only)	II
▪ Toledo (ZIP Codes beginning with 434 – 436 only)	II
▪ Youngstown (ZIP Codes beginning with 444 – 454 only)	II
▪ Remainder of State	I
Oklahoma	II
Oregon	II
Pennsylvania	
▪ Philadelphia (ZIP Codes beginning with 190 – 191 only)	III
▪ Pittsburgh (ZIP Codes beginning with 150 – 152 only)	III
▪ Remainder of State	II
Puerto Rico	III
Rhode Island	III
South Carolina	I
South Dakota	I

Geographic Schedule	
Dentist's Office Location	**Schedule**
Tennessee	
▪ Nashville (ZIP Codes beginning with 372 only)	III
▪ Memphis and Knoxville (ZIP Codes beginning with 379 and 381 only)	II
▪ Remainder of State	I
Texas	
▪ Houston Area (ZIP Codes beginning with 770 – 772 and 774 – 775 only)	III
▪ Dallas, Fort Worth Areas (ZIP Codes beginning with 750 – 753 and 760 – 761 only)	III
▪ Corpus Christi Area (ZIP Codes beginning with 783 – 784 only)	III
▪ Austin Area (ZIP Codes beginning with 786 – 787 and 789 only)	III
▪ Remainder of State	II
Utah	I
Vermont	II
Virginia	
▪ Washington, D.C. Area (ZIP Codes beginning with 220 – 223 only)	III
▪ Remainder of State	II
Virgin Islands	II
Washington	
▪ Seattle and Tacoma Areas (ZIP Codes beginning with 980 – 984 only)	III
▪ Remainder of State	II
West Virginia	I
Wisconsin	II
Wyoming	II
Outside of the United States and not listed above	III

WHAT'S COVERED UNDER DENTAL OPTION A AND DENTAL OPTION B

Generally, dental services (including most oral surgery) are eligible for benefits to the extent they are necessary and appropriate for dental health and are considered eligible procedures under the appropriate schedule of services. To verify coverage and for specific information on any procedure, you should contact a MetLife customer service representative.

Dental Option A and Dental Option B

		Benefit Allowance Schedule			
Procedure Code	**Service**	**I**	**II**	**III**	**IV**
Oral Examination (up to 2 for each covered individual per calendar year)[1]					
0150	Comprehensive	$15	$17	$19	$21
0120	Periodic	$14	$16	$18	$20
X-Rays					
0210	Complete mouth series, single or multiple films (limit one complete mouth series or panoramic x-ray per 36 months)	$41	$46	$52	$52
0220	Single periapical, first film	$7	$7	$8	$9
0230	Periapical, each additional film	$3	$4	$4	$4
0230	Bite-wing (limit 2 times per calendar year)				

1 Additional oral exams may be allowed for coverage upon appeal to the contract administrator if deemed medically necessary by the contract administrator.

Dental Option A and Dental Option B

		Benefit Allowance Schedule			
Procedure Code	Service	I	II	III	IV
0270	• Single film	$9	$10	$11	$12
0272	• Two films	$12	$13	$14	$15
0274	• Four to six films	$16	$18	$20	$22
0277	• Seven to eight films	$18	$20	$22	$24
0330	Panoramic x-ray (limit one complete mouth series or panoramic x-ray per 36 months)	$35	$39	$43	$48
Prophylaxis cleaning and polishing (up to 2 for each covered individual per calendar year)					
1110	Adult	$29	$33	$38	$42
1120	Child until reaching 15th birthday	$20	$22	$25	$27
Topical Fluoride Treatments (limit once per calendar year)					
1208	One treatment – child	$16	$18	$20	$22
1208	One treatment – adult	$16	$18	$20	$22
Space Maintainers					
1510	Fixed	$108	$122	$138	$151
1520	Removable	$121	$138	$154	$171
Amalgam Filling (primary and permanent teeth)					
2140	Amalgam filling (primary and permanent teeth)	$18	$21	$23	$25
2150	Amalgam filling (primary and permanent teeth)	$28	$31	$34	$37
2160	Amalgam filling (primary and permanent teeth)	$34	$39	$43	$47
Composite Filling (primary and permanent teeth)					
2330	One surface	$26	$29	$33	$36
2331	Two surfaces	$32	$35	$39	$43
2332	Three surfaces	$38	$42	$47	$53
Crowns (includes temporary crown) – Replacement limited to once every 5 years					
2722	Resin with noble metal	$208	$235	$263	$291
2740	Porcelain/ceramic substrate	$219	$250	$279	$310
2750	Porcelain fused to high noble metal	$239	$272	$305	$337
2790	Full cast, high noble metal	$232	$264	$295	$327
Root canal therapy (removal of pulp and canal filling, excluding final restoration)					
3310	Anterior tooth	$129	$147	$164	$182
3320	Bicuspid tooth	$162	$184	$206	$227
3330	Molar tooth	$196	$223	$250	$277
Gingivectomy					
4210	Per quadrant	$86	$98	$110	$122
Osseous Surgery (including flap entry and closure)					
4260	Per quadrant (limit 4 per 36 months)	$219	$250	$279	$310
Periodontal Scaling and Root Planing. These schedule amounts apply only when fewer than four quadrants (full mouth) are treated in one visit. Specific criteria may apply depending on pocket of depth and loss of attachment (bone loss).					
4341	Per quadrant (limit eight per calendar year)	$34	$38	$42	$47

Dental Option A and Dental Option B

		Benefit Allowance Schedule			
Procedure Code	Service	I	II	III	IV
4910	Periodontal Maintenance – four per calendar year (including 1110/1120)	$34	$38	$42	$47
Dentures[2] (including six months post-placement care, limit one per five years to include bridgework)					
5110, 5120	Complete upper or lower	$278	$316	$353	$392
5211, 5212	Partial, upper or lower	$232	$265	$296	$328
5421, 5422	Adjust partial denture, upper or lower	$14	$16	$18	$20
Implant[2]					
6010	Endosteal implant	$404	$457	$509	$567
Extraction-simple and surgical[3] (including local anesthesia and routine post-operative care)					
7210	Surgical extraction single erupted tooth	$37	$41	$46	$50
7220	Surgical extraction single impacted tooth (soft tissue)	$57	$64	$71	$79
7140	A simple extraction of an erupted tooth or exposed root	$20	$22	$25	$28
Temporomandibular Joint Dysfunction (TMJ)[3]					
0321	X-ray up to six views	$35	$39	$44	$49
7880	TMJ appliance	$208	$235	$263	$291
7899	Office visit/treatment (limit 10)	$53	$59	$65	$72
Orthodontics – Comprehensive treatment					
	Initial payment	$384	$384	$384	$384
	Monthly payments (during active treatment period)	$62	$62	$62	$62
	Orthodontic workup	$100	$100	$100	$100

TMJ Treatment (Dental Option A)

Where there is a temporomandibular joint dysfunction (TMJ) diagnosis, related charges are reimbursed in accordance with the benefit allowance schedule on the previous page. Services related to TMJ which are not listed in the schedule are not eligible for benefits under the IBM Dental Option A or Option B. A maximum of 10 office visits per year is allowed, including eligible services of other providers for associated treatment.

TMJ-related charges that are not covered under the IBM Dental Option A — such as an MRI for diagnostic purposes or TMJ surgery — may be eligible for IBM medical benefits in certain rare circumstances. If you wish to know whether medical benefits would apply for TMJ expenses in your particular circumstances, you should consult the health plan before you incur the expense.

There is no TMJ coverage under Dental Option B.

2 Benefits are available for dental implants, however a pre-authorization is required for implants and other related services. No benefits are available without pre-authorization.
3 Generally, services for anesthesia/analgesia will be reviewed by MetLife for dental necessity. Also reimbursement for anesthesia/analgesia will be combined with the benefit for other services rendered on the same day.

Orthodontic Treatment (Dental Option A)

Typically, orthodontics is performed over a number of visits, and the services are charged as a lump-sum fee that covers the entire process. The administration of the comprehensive orthodontic benefit differs from that of other dental services. After the active treatment phase has commenced — after placement of the bands upon the teeth — an initial comprehensive treatment payment will be made to you upon submission of the IBM Dental Plan claim form. This payment is for the necessary appliances, diagnostic casts, x-rays and sub-sequent retention visits during active treatment (while the bands are on the teeth). Active treatment will end when the bands are removed and no further reimbursement for retention visits will be made.

You will also be entitled to receive monthly payments up to a maximum benefit (for all orthodontic care) of $1,500 for the duration of active treatment or until the completion of the treatment plan, whichever comes first. Treatments will be recertified periodically. The orthodontics benefit allowance schedule is the same for all geographic areas. Do not wait for treatment to end before submitting claims to MetLife as the claim filing submission deadline applies. For more information, see "How to File a Claim" in the Administrative Information section.

Eligible services considered orthodontic in nature include removable/permanent appliances, minor or intermediate. These appliances are not considered comprehensive orthodontic treatment. Unlike comprehensive orthodontic treatment, these appliances will be reimbursed like any other dental services. In addition to reimbursement for the actual appliance, you are eligible for six orthodontic office visits. Reimbursement for both will be paid in one lump-sum payment. However, such orthodontic appliances are included in the $1,500 lifetime maximum.

Retainers are not covered as a separate benefit.

There is no orthodontia coverage under Dental Option B.

Replacement of Dentures or Bridgework (Dental Option A)

Benefits for the replacement of existing dentures or bridgework will be provided only under the following conditions:

- The existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable or
- The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge or
- The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge

- Relines will not be eligible for coverage until six months after insertion of prosthesis; then no limit

Any dental treatment for dentures or bridgework received under the IBM Dental Plan will be treated as if it was received under the IBM Dental Plan Option A. For example, if a covered individual received dentures or bridgework less than five years ago under the IBM Dental Plan and that individual is now covered under the IBM Dental Plan Option A, new dentures or bridgework may not be replaced unless the existing denture or bridgework cannot be made serviceable.

Pretreatment Estimate of Benefits

Upon request, MetLife will provide an estimate of benefits based on anticipated dental treatment. This should be done if your dentist recommends a dental procedure that exceeds $200. To obtain this estimate of benefits, have your dentist submit a claim form reflecting the proposed treatment plan and relevant clinical information, e.g. X-rays or narrative. MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method. A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements because of frequency limits or plan limitations.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate because of Plan limitations (such as frequency limits and annual and lifetime maximums) i l coverage — actual payments will be less if there is other dental coverage that is primary. No benefits are payable for services performed after termination of coverage.

Alternative Benefits

MetLife reserves the right to suggest an alternate treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternate method is identified, benefits will be based on the least costly generally-acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternate benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings: Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally-accepted method of repair. Replacement of existing crowns, inlays and onlays – once every five years – may be waived for dental necessity. Composite fillings on molar teeth are subject to the alternate benefit provision. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.
Bridgework and Dentures	Dental benefits will be based on the least-costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.

Dental Service	Alternative Treatment
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is required prior to work being done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternate benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternate benefit provision. An alternate benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.

Dental Claim Review Procedures

Dental claim review procedures have been established to ensure that the reimbursements accurately reflect the services performed. In certain cases, x-rays and other diagnostic and evaluation materials may be requested to assist in the review.

Filing Claims

See "How to File a Claim" in the Administrative Information section for instructions.

HOW THE METLIFE PREFERRED DENTIST PROGRAM (PDP) WORKS

The MetLife Preferred Dentist Program (PDP) is available to pre-2000 eligible retirees who are not Medicare-eligible, their eligible family members who are not Medicare-eligible, and those enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO). The PDP provides financial assistance toward the expenses of dental care and treatment. Under the PDP option, you can visit any licensed dentist of your choice, but you will receive the highest level of coverage when you obtain services from a dentist who is a member of MetLife's network. (Major restorative and orthodontic services are not eligible for reimbursement when using an out-of-network dentist.)

Annual Deductible

There is no annual deductible under the PDP option. Also, you do not have to choose a primary care dentist, nor do you need authorization to switch dentists or to seek specialty care, although specialists must be participating PDP providers in order for expenses to be eligible for reimbursement.

Lifetime Maximum

Under the PDP there is no lifetime maximum, except for orthodontic treatment which has a lifetime maximum of $1,500 for each covered person.

In-Network Providers

You can take advantage of negotiated rates when you receive treatment from a participating PDP network dentist. When you receive services from a PDP participating dentist, benefit payments are based on a percentage of the dentist's negotiated fees. The percentage reimbursed varies for procedures received (see "What's Covered Under the Preferred Dentist Program" for details). Also, the negotiated rates vary by geographic location and are agreed to by the PDP Dentist and MetLife in advance. The reimbursements apply to eligible services performed by a PDP participating dentist wherever they are performed, such as the dentist's office or the hospital. Please check with your medical plan regarding precertification of your hospital stay.

If you use a provider who practices at more than one location, the provider may not participate in the network in all of their locations. Prior to obtaining any dental service, you should verify the provider's network participation at the location you visit by contacting MetLife. Also, if a member of a dental practice is a participating MetLife network dentist, it is possible that other dentists in that practice are not. You should check with MetLife regarding eligibility of other dentists before having treatment rendered.

IF YOU RELOCATE OR YOUR PROVIDER LEAVES THE NETWORK

If you relocate or your provider leaves the PDP network, you are not eligible to change your dental plan options during the year as these events are not considered qualified status changes. You may change dental options only during the annual benefit enrollment period or if you have a qualified status change.

When making an appointment, tell the dentist's office that you are a MetLife PDP dental plan participant. By making the dentist's office aware that you are a network plan participant, you will receive the negotiated rates and avoid later billing adjustments.

Since participating providers can join and leave the network at any time, it's a good idea to confirm that your dentist is currently a network provider prior to receiving treatment. You can obtain a list of current network participating providers through www.metlife.com/m lling MetLife.

Geographic Areas

The negotiated fees charged by participating dentists reflect differences in negotiated dental charges by geographic area. Each participating PDP network dentist agrees to accept a geographically-based negotiated rate as payment in full. That fee determines what the dentist will charge for services to eligible IBM retirees. These geographically-based negotiated rates are not published to retirees, but you may contact MetLife for reimbursement rates for specific procedures.

Out-of-Network Providers

You may visit any appropriately-licensed dentist of your choice. However, if that dentist is not a participating PDP network dentist, eligible services are limited to preventive, diagnostic and some basic services only. Major restorative and orthodontic services are not eligible for reimbursement when using an out-of-network dentist.

The out-of-network reimbursement is based on a fixed dollar amount, and follows the same benefit allowance as Schedule III of Dental Option A and Dental Option B (see "What's Covered Under Dental Option A and Dental Option B" charts).

If you cannot locate a PDP provider within a reasonable distance from your home or work, you must contact MetLife before services are rendered. A Customer Service Representative will help you determine your alternatives by checking to see if additional dentists were added to the PDP network in your area.

Filing Claims

You should bring a PDP claim form to all dental appointments, whether you receive services in-network or out-of-network. You can obtain PDP claim forms on MetLife's web site or by calling MetLife. See "How to File a Claim" in the Administrative Information section for more information.

Pretreatment Estimate of Benefits

If your dentist recommends substantial t (in excess of $200), you should request a pretreatment estimate of benefits from MetLife by having your dentist submit a claim form with an explanation of the treatment plan and relevant clinical information, e.g., x-rays or narrative. MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method (see next page). A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements be-cause of frequency limits or plan limitations.

PAYING FOR DENTALSERVICES BY IN- AND OUT-OF-NETWORK DENTISTS

At the time you receive dental services, your dentist may require you to pay the amount of your copayment or the full negotiated fee. Your copayment is the difference between the amount of the dentist's charges, up to the usual and prevailing rate if you visit an out-of-network provider, and the percentage paid by MetLife for that type of service.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate because of Plan limitations (such as frequency limits and Plan maximums) in effect when services are performed. Pretreatment estimates assume you do not have any other dental coverage — actual payments will be less if there is other dental coverage that is primary.

If you do not obtain a pretreatment estimate, or choose a treatment not authorized for benefits by Met-Life, you will be responsible for any difference in cost between the suggested alternate treatment, if any, and the treatment you receive.

No benefits are payable for services performed after termination of coverage.

Alternative Benefits

MetLife PDP reserves the right to suggest an alternate treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternate method is identified, benefits will be based on the least costly professionally-acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternate benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings: Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally-accepted method of repair. Replacement of existing crowns, inlays and onlays — once every 5 years — may be waived for dental necessity. Composite fillings on molar teeth are subject to the alternate benefit provision. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.

Dental Service	Alternative Treatment
Bridgework and Dentures	Dental benefits will be based on the least costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is required prior to work being done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternate benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternate benefit provision. An alternate benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.

Emergency Care under the MetLife PDP

If emergency dental treatment is required, contact your PDP dentist. If your PDP dentist is not available, you should go to another PDP dentist. However, if a PDP dentist is not available, it is understandable that treatment may be sought from a non-PDP dentist for palliative care (to alleviate pain).

In a case when emergency dental treatment is required and you have gone to an out-of-network dentist, benefits to alleviate the pain which led to the emergency will be considered for reimbursement. Supporting documentation will be required from you and your dentist; the documentation should fully explain why a PDP dentist was not visited and the nature of the dental emergency.

When using a non-PDP dentist, reimbursement is not guaranteed, therefore sufficient supporting documentation must be submitted with the claim since each case will receive individual consideration. This documentation along with the bill for services is to be submitted with the PDP claim form to MetLife. MetLife will then review documentation and determine eligibility for reimbursement.

WHAT'S COVERED UNDER THE METLIFE PREFERRED DENTIST PROGRAM

Generally, dental services (including most oral surgery) are eligible for benefits to the extent they are necessary and appropriate for dental health and are considered eligible procedures under the appropriate schedule of services. To verify coverage and for specific information on any procedure, you should contact a MetLife customer service representative.

Procedure Code	Service	Reimbursement: In-Network	Reimbursement: Out-of-Network
Oral Examination[1] (up to 2 for each individual per calendar year)			
0150	Comprehensive	100%	$19
0120	Periodic	100%	$18
X-Rays			
0210	Complete mouth series, single or multiple films (limit 1 complete mouth series or panoramic x-ray per 36 months)[2]	80%	$52
0220	Single periapical, first film	80%	$8
0230	Periapical, each additional film	80%	$4
Bite-wing (limit 2 times per calendar year)			
0270	Single film	80%	$11
0272	Two films	80%	$14
0274	Four to six films	80%	$20

Procedure Code	Service	Reimbursement: In-Network	Reimbursement: Out-of-Network
0277	Seven to eight films	80%	$22
0330	Panoramic x-ray (limit 1 complete mouth series or panoramic x-ray per 36 months)	80%	$43
Prophylaxis — Cleaning and Polishing (up to 2 for each individual per calendar year)			
1110	Adult	80%	$38
1120	Child until reaching 15th birthday	80%	$25
Topical Fluoride Treatments (limit once per calendar year)			
1208	One treatment – child	80%	$20
1208	One treatment – adult	80%	$20
Space Maintainers			
1510	Fixed	80%	$138
1520	Removable	80%	$154
Amalgam Filling (primary and permanent tooth)			
2140	One surface	50%	$23
2150	Two surfaces	50%	$34
2160	Three surfaces	50%	$43
Composite Filling			
2330, 2391	One surface	50%	$33
2331, 2392	Two surfaces	50%	$39
2332, 2393	Three surfaces	50%	$47

What's Covered under the Preferred Dentist Program – In-Network Coverage Only

Procedure Code	Service[3]	Reimbursement: In-Network
Crowns (includes temporary crown) – Replacement limited to once every 5 years		
2722	Resin with noble metal	50%
2740	Porcelain/ceramic substrate	50%
2750	Porcelain fused to high noble metal	50%
2790	Full cast, high noble metal	50%
Root canal therapy (removal of pulp and canal filling, excluding final restoration)		
3310	Anterior tooth	50%
3320	Bicuspid tooth	50%
3330	Molar tooth	50%
Gingivectomy		
4210	Per quadrant	50%
Osseous Surgery (including flap entry and closure)		
4260	Per quadrant (limit 4 per 36 months)	50%
Periodontal Scaling and Root Planing – These schedule amounts apply only when fewer than four quadrants (full mouth) are treated in one visit. Specific criteria may apply depending on pocket of depth and loss of attachment (bone loss).		
4341	Per quadrant (limit 8 per calendar year)	50%
4910	Periodontal Maintenance - four per calendar year (including 1110/1120)	50%
Dentures[3] (including six months post-placement care, limit one per five years to include bridgework)		
5110, 5120	Complete upper or lower	50%
5211, 5212	Partial, upper or lower	50%

Procedure Code	Service[3]	Reimbursement: In-Network
5421, 5422	Adjust partial denture; upper or lower	50%
Implants[3]		
6010	Surgical placement of implant body	50%
Extraction - simple and surgical (including local anesthesia and routine post-operative care)		
7210	Surgical extraction of a single erupted tooth	50%
7220	Surgical extraction of a single impacted tooth (soft tissue)	50%
7140	A simple extraction of an erupted tooth or exposed root	50%
Temporomandibular Joint Dysfunction (TMJ)		
0321	X-ray up to six views	80%
7880	TMJ appliance	50%
7881	Office visit/treatment (limit 10)	50%

1 Additional oral exams may be allowed for coverage upon appeal to the contract administrator if deemed medically necessary by the dental plan.
2 The limitation on receiving complete mouth series x-rays and panoramic x-rays in a 36-month period will be carried over from any other IBM Dental Plan to the PDP. For example, if you or a covered dependent have received a complete mouth x-ray series within the last 36-months under IBM Dental Plan A or B, you or the covered dependent will have to wait until the 36-month period has been reached prior to receiving a complete mouth x-ray series or panoramic x-ray series under the PDP.
3 Benefits are available for dental implants; however, a pre-authorization is required for implants and other related services. No benefits are available without pre-authorization.

TMJ Treatment (In-Network Coverage Only)

Where there is a temporomandibular joint dysfunction (TMJ) diagnosis, in-network related charges are reimbursed in accordance with the following reimbursement percentages. Services related to TMJ which are not listed in the schedule are not eligible for benefits under the MetLife PDP. A maximum of 10 office visits per year is allowed, including eligible services of other providers for associated treatment.

TMJ-related charges not covered under the MetLife PDP may be eligible for IBM medical benefits in certain rare circumstances. If you wish to know whether medical benefits would apply for TMJ expenses in your particular circumstances, you should consult with your medical plan before you incur the expense.

Orthodontic Treatment (In-Network Coverage Only)

Orthodontic treatment that commences on or after the effective date of coverage in the PDP will be covered for eligible PDP participants, up to a lifetime maximum of $1,500 per covered person. The administration of the orthodontic benefit differs from that of other dental services. Here's how:

- When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, additional information may be requested periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form.
- After the active treatment phase has commenced — placement of the bands upon the teeth — 25% of the total orthodontic charge will be considered the banding fee. Benefits will be paid at 50% of the banding fee, or up to the usual and prevaili ll be made upon submission of the claim form.
- After subtracting the banding fee, the remaining charge for eligible services while the bands are on the teeth will be divided by the number of months of treatment that the orthodontist indicates is required. (Charges include necessary appliances, diagnostic casts, x-rays and subsequent monthly visits while the bands are on the teeth.)

- You will receive a monthly reimbursement check equal to 50% of this calculated monthly amount. Payment for active treatment will en
  ll be
  made.
- Reimbursement will be paid in monthly installments over the course of the treatment, thus the full reimbursement will not be received until conclusion of the active treatment has been reached. Monthly benefits will be sent automatically to you or to your dentist, per your designation on the claim form. (Automatic payment will cease if you or your covered family member are no longer covered by the PDP.)
- Do not wait for treatment to be completed to submit orthodontia claims as the claim submission deadlines apply. For more information, see "How to File a Claim" in the Administrative Information section.
- MetLife will confirm treatment periodically.

Eligible Orthodontic Services

Eligible services considered orthodontic in nature include removable or fixed appliances and minor or intermediate appliances. All orthodontic appliances are included in the $1,500 lifetime maximum. Retainers are not covered as a separate benefit. There is no coverage for orthodontic treatment if services are rendered by an orthodontist who is not a PDP-participating provider.

Orthodontic Benefits If You Received Services under IBM Dental Option A

If an individual covered under the PDP commences orthodontic services on or after the effective date of coverage and had previously received orthodontic services under IBM Dental Plan Option A, any amount reimbursed to the retiree for orthodontic services while under the IBM Dental Plan will be deducted from the $1,500 PDP orthodontic lifetime maximum. The covered individual will only be reimbursed at the 50% level up to the remaining balance of the $1,500 maximum.

Treatment for the Replacement of Dentures or Bridgework (In-Network Coverage Only)

Benefits for the replacement of existing dentures or bridgework will be provided only under the following conditions:

- The existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable or
- The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge and the appliance cannot be made serviceable or
- The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.
- Relines will not be eligible for coverage until six months after insertion of prosthesis; then no limit.

Any dental treatment for dentures or bridgework received under the IBM Dental Plan will be treated as if it was received under the PDP. For example, if a covered individual received dentures or bridgework less than five years ago under the IBM Dental Plan and that individual is now covered under the PDP, new dentures or bridgework may not be replaced unless the existing denture or bridgework cannot be made serviceable.

Dental Claim Review Procedures

Dental claim review procedures have been established to ensure that the reimbursements accurately reflect the services performed. In certain cases, x-rays and other diagnostic and evaluation materials may be re-quested to assist in the review.

Reimbursement of orthodontic expenses or other courses of treatment for patients whose treatment started before their PDP coverage began will be reviewed by MetLife for any eligible benefits.

Benefit Guidelines for General Anesthesia/IV Sedation

Benefits may be available, as determined by the Contract Administrator, for general anesthesia/IV sedation when it is performed in conjunction with the following dental procedures:

- The surgical extraction of two or more teeth completed on the same date.
- When three or more standard extractions of teeth are completed on the same date.
- The closure of an oral antral fistula.
- The surgical exposure of an impacted tooth that is to be retained for orthodontic purposes if orthodontics is covered by the Plan.
- When two or more implants are placed and the implants have been approved for benefits.
- When a standard tooth extraction and a surgical tooth extraction are completed on the same day.

There may be occasions where benefits for general anesthesia/IV sedation are available when a patient has unique needs or where there are clinical situations that warrant its use because local anesthesia administration would not suffice. Some examples include:

- Mentally- or physically-disabled covered individuals.
- Age of patient — up to seven years — unmanageable.
- Patient with spastic disease.
- Infection at injection site where local anesthetic would normally be administered.
- Allergy to local anesthesia.
- Failure of local anesthesia to control pain.
- Extent of surgery — complicated surgical procedures that occur in multiple quadrants of the oral cavity on the same date.

Benefit Guidelines for Local Chemotherapeutic Agents

In Conjunction with Non-Surgical Periodontal Therapy

Benefits for the application of local chemotherapeutic agents during non-surgical therapy are limited to one per tooth and for a limited number of teeth, determined by the dental administrator's Dentist Consultants, that have pocket depth between 6MM and 8MM and bleed on probing.

In Conjunction with Periodontal Maintenance Therapy

Benefits for the application of local chemotherapeutic agents may be available based on review of the clinical documentation by the dental administrator's Dentist Consultants when there is a history of completed active periodontal therapy. The benefits are limited to one per tooth for a limited number of teeth that show increasing pocket depths between 5MM and 8MM and have had no chemotherapeutic agent applied for at least the prior 12-month period.

Dental Options for Retirees Who Retired On or After January 1, 2000

Retirees who are not eligible for Medicare, non-Medicare dependents of Medicare-eligible retirees and those enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) can enroll in the dental plan options described below.

IBM DENTAL PLAN AT A GLANCE FOR POST-2000 RETIREES[1]

	IBM Dental Basic		IBM Dental Plus	
Annual Deductible				
In-Network	None		None	
Out-of-Network	None		$50 per person for basic and major restorative treatment; waived for preventive treatment;	
Annual Maximum Benefit	$500 per covered person		$2,000 per covered person[2]	
Lifetime Maximum Benefit	No limit		No limit	
Orthodontia Lifetime Maximum	Not applicable		Up to $1,500 per covered person	
Level of Care	The Plan Pays			
	In-Network	*Out-of-Network*[3]	*In-Network*	*Out-of-Network*[3]
Preventive Treatment	100% of the negotiated fee for eligible charges	80% of usual & prevailing rate	100% of the negotiated fee for eligible charges	80% of usual & prevailing rate
▪ Routine oral exams				
▪ Routine cleanings				
▪ X-rays				
▪ Fluoride treatments				
▪ Space maintainers				
▪ Sealants				
Basic Restorative Treatment	80% of the negotiated fee for eligible charges	80% of usual & prevailing rate, after deductible	80% of the negotiated fee for eligible charges	80% of usual & prevailing rate, after deductible
Amalgam and composite fillings				
Annual Deductible				
In-Network	None		None	
Out-of-Network	None		$50 per person for basic and major restorative treatment; waived for preventive treatment;	
Annual Maximum Benefit	$500 per covered person		$2,000 per covered person[2]	
Major Restorative Treatment[9]	Not covered	Not covered	50% of the negotiated fee for eligible charges	50% of usual & prevailing rate, after deductible
▪ Crowns and bridgework				
▪ Dentures				
▪ Extractions				
▪ Implants[4]				
▪ Inlays and onlays				
▪ Oral surgery that is dental in nature				
▪ Periodontal services, including periodontal scaling and root planing				
▪ Endodontics, including root canals				

	IBM Dental Basic		IBM Dental Plus	
Orthodontia ▪ Examinations ▪ Diagnostic procedures ▪ Appliances, including re-movable, fixed and minor or intermediate appliances	Not covered	Not covered	50% of the negotiated fee for eligible charges	50% of usual & prevailing rate

1 If you became eligible for LTD benefits on or after January 1, 2000, special provisions apply under IBM Dental Plus. See your Health Plan Detail Sheets for details.
2 Orthodontia charges do not count towards the annual maximum benefit.
3 You are responsible for 100% of any charges above the usual and prevailing rate.
4 A pre-treatment estimate is required for implants and implant-related services prior to work being done.
5 There are replacement and frequency limitations for some of the above services. Refer to "What's Covered under the IBM Dental Plan."

Usual and Prevailing Rate

The usual and prevailing rate for out-of-network dental services is defined as the maximum fee consideration the following:

- The fee that an individual dentist most frequently charges the majority of patients for a similar service or dental procedure.
- The range of usual fees charged for the service or procedure by dentists for the performance of a similar service or dental procedure within the same locality.
- Special circumstances or complications requiring additional time, skill and experience in connection with that particular dental service or procedure.

MetLife shall determine usual and prevailing rate information in all cases. Keep in mind the usual and prevailing rate may be different than the amount charged by an out-of-network dental provider. If the charge for services is more than the usual and prevailing rate set by the Plan, you will have to pay your provider the amount that exceeds the usual and prevailing rate, in addition to the applicable deductible and coinsurance.

HOW THE IBM DENTAL PLAN WORKS

Under the IBM Dental Basic and IBM Dental Plus options, you can visit any licensed dentist of your choice, but you will receive the highest level of coverage when you obtain services from a dentist who is a member of MetLife's network. Charges used to satisfy the deductible will not be eligible for reimbursement under any other dental benefit plan. Under IBM Dental Plus each member must satisfy the deductible each calendar year if seeing a provider outside of MetLife's network for Basic and Major Restorative services.

IF YOU SWITCH FROM THE IBM DENTAL PLUS TO THE IBM DENTAL BASIC OPTION

If you change your enrollment from the IBM Dental Plus option to the IBM Dental Basic option during annual enrollment or in the middle of the year due to a qualified status change, dental treatment "in progress" at the time of your enrollment change will become ineligible for coverage unless the services continue to be eligible under the IBM Dental Basic option.

For example, if your child is receiving orthodontia treatment under the IBM Dental Plus and you change enrollment to the IBM Dental Basic, that treatment will no longer be covered since orthodontia care is not a covered service under the IBM Dental Basic option.

The applicable annual maximum carries over to/ from Dental Basic and Dental Plus when plan changes occur during the same calendar year. For example, if you make a mid-year plan change to Dental Basic from Dental Plus and you've already used $200 towards your annual maximum under Dental Plus, you will have $300 remaining towards your new annual maximum under Dental Basic ($500) for the remainder of the plan year.

In-Network Providers

You can take advantage of negotiated rates when you receive treatment from a participating MetLife network dentist. Plus, your network dentist will submit your claim to MetLife for you so there are no claim forms to fill out. Additionally, you are not required to pay an annual deductible for in-network treatment.

When you receive services from a MetLife participating dentist, benefit payments are based on the dentist's negotiated fees. When making an appointment, tell the dentist's office that you are a MetLife dental plan participant. By making the dentist's office aware that you are a network plan participant, you will receive the negotiated rates and avoid later billing adjustments from an in-network provider.

If you use a provider who practices at more than one location, the provider may not participate in the network in all of their locations. Prior to obtaining any dental service, you should verify the provider's network participation at the location you visit by contacting MetLife. Also, if a member of a dental practice is a participating MetLife network dentist, it is possible that other dentists in that practice are not.

Since participating providers can join and leave the network at any time, it's a good idea to confirm that your dentist is currently a network provider prior to receiving treatment. You can obtain a list of current network participating providers through www.metlife.com/mybenefits or by calling MetLife.

Geographic Areas

The negotiated fees charged by participating dentists reflect differences in negotiated dental charges by geographic area. Each participating MetLife network dentist agrees to accept a geographically-based negotiated rate as payment in full. That fee determines what the dentist will charge for services to eligible IBM employees. These geographically-based negotiated rates are not published to employees, but you may contact MetLife for reimbursement rates for specific procedures.

Out-of-Network Providers

You may visit any appropriately-licensed dentist of your choice. However, if that dentist is not a participating MetLife network dentist, reimbursement will be based on a percentage of the usual and prevailing rate. Additionally, you must satisfy a $50 per person annual deductible when utilizing an out-of-network dentist for basic and major restorative treatment. The out-of-network annual deductible does not apply to preventive care or orthodontia treatment. If you receive treatment from an out-of-network dentist, you are also responsible for filing your own claims. See "How to File a Claim" in the Administrative Information section for more information.

Charges used to satisfy the deductible will not be eligible for reimbursement under any other dental benefit plan. Each member must satisfy the deductible each calendar year.

Pretreatment Estimate of Benefits

If your dentist recommends substantial treatment (in excess of $200), you should request a pretreatment estimate of benefits from MetLife by having your dentist submit a claim form with an explanation of the treatment plan and relevant clinical information, e.g., x-rays or narrative. MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method (see next page). A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements because of frequency limits or plan limitations.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate because of Plan limitations (such as frequency limits and annual and lifetime maximums) i

, or choose a treatment not authorized for benefits by MetLife, you will be responsible for any difference in cost between the suggested alternate treatment, if any, and the treatment you receive.

PRETREATMENT ESTIMATE FOR IMPLANTS AND RELATED SERVICES

A pretreatment estimate is recommended for implants and other related services prior to work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.

Alternative Benefits

MetLife reserves the right to suggest an alternate treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternate method is identified, benefits will be based on the least costly generally-acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternate benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings: Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally-accepted method of repair. Replacement of existing crowns, inlays and onlays -- once every five years -- may be waived for dental necessity. Composite fillings on molar teeth are subject to the alternate benefit provision. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.
Bridgework and Dentures	Dental benefits will be based on the least-costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is recommended prior to work being done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternate benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternate benefit provision. An alternate benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.